

IDAHO DEPARTMENT

HEALTH & WELFARE

C. L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

July 11, 2008

Chuck Lloyd Mountain View Center For Geriatric Psychiatry 500 Polk Street East Kimberly, ID 83341

Provider #134014

Dear Mr. Lloyd:

On May 22, 2008, a Complaint Survey was conducted at Mountain View Center For Geriatric Psychiatry. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003419

Allegation: Patients are overmedicated.

Findings:

An unannounced visit was made to the hospital on May 22, 2008. Seven current and closed medical records were reviewed. Patients were observed. Occurrence reports were reviewed. Staff were interviewed.

Documentation for all of the medical records reviewed stated patients were awake most of the day. Documentation demonstrated physicians checked on the status of their patients' daily and made medication adjustments when necessary. Nurses communicated throughout the day with the physicians, if necessary. The communication between all staff is well-documented in each patient's medical record. Documentation included 15 minute welfare checks, copies of faxes sent to the physicians, and nursing notes describing the condition of the patient.

Six of seven observed patients were awake and well supervised by Certified Nursing Assistants in the hallways and in the day room. None of the patients displayed signs/symptoms of oversedation. The patients interacted with the nursing staff, visitors, and their peers at the facility.

The seventh patient took a nap after lunch, then joined the other patients in the day room for social interaction.

Three nursing assistants, a physician, an activities director and a nurse were interviewed about oversedation of patients. All responded that oversedation of patients rarely occurred at this facility. The physician explained his rationale for making medication changes.

No incidents of injuries or problems related to sedation of patients were present in the facility's occurrence reports.

The closed chart of one of the patients involved in the complaint was thoroughly reviewed. No recorded falls or occurrences of harm were documented for this patient. The patient spent most of each day awake and staff appeared attentive to her needs.

The facility was observed to have sufficient numbers of staff to meet patient needs. Staff were observed to be attentive to patients.

No instances of oversedation of patients were evident. No deficiencies were cited.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES

Health Facility Surveyor

Non-Long Term Care

SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

GG/mlw